

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/29/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW	STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An annual recertification survey and an abbreviated survey (KY #18520 and KY #18521) was conducted on 06/12/12 through 06/15/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with deficiencies cited at the highest S/S of a "D." KY #18520 was substantiated with no deficiencies. KY #18521 was unsubstantiated with no deficiencies.	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to promote care for residents in a manner that maintained or enhanced each residents' dignity and respect for one resident (#2), in the selected sample of twenty-four residents. Findings include: A review of the facility's "Quality of Life" policy/procedure, dated 10/31/10, revealed the resident was encouraged and assisted to dress in their own clothes appropriate to the season, time of day, and individual preferences.	F 241	F-241 1) Resident #2 no longer resides at the facility. 2) The Director of Nursing (DNS) or designee will assess resident's personal hygiene, dress and grooming. The Social Service Director (SSD) or designee will identify through individual interviews on admission with residents and families regarding resident's choice for dressing and grooming. 3) The Staff Development Coordinator (SDC) or designee will provide inservice to the nursing staff on providing proper grooming, dress and hygiene for residents. The SDC will include information regarding maintaining and/or enhancing resident dignity in the orientation of all new personnel.	7/30/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *7/6/12*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	<p>Continued From page 1</p> <p>A record review revealed the facility admitted Resident #2 on 03/24/12 with diagnoses to include Dementia, Hypertension, Hyperlipidemia, Congestive Heart Failure, Angina, Syncope, Asthma, Reflux, Old Myocardial Infarction, LE CVA, Orthostatic Hypotension, Urinary Tract Infection, Irritable Bowel Syndrome, Urine Retention, and Osteoporosis. A review of the initial Minimum Data Set (MDS), dated 04/25/12, revealed the facility assessed the resident as cognitively intact. The resident required extensive assistance with dressing, bathing, and hygiene. The interview for daily preferences, according to the MDS, revealed it was very important for the resident to choose what clothes to wear.</p> <p>An observation during the initial tour, on 06/12/12 at 7:00 PM, revealed Resident #2 was lying in his/her bed wearing only a brief and a shirt. A sheet partially covered the resident's lower extremities; however, the resident's brief was visible. There were two female visitors and one male visitor present in the room.</p> <p>Interview with Resident #2, on 06/12/12 at 7:00 PM and on 06/14/12 at 9:00 AM, revealed he/she liked to wear pants while in the bed, and without pants, it made him/her feel "useless" when visitors were present.</p> <p>An interview with the resident's family, on 06/12/12 at 7:00 PM, revealed when the resident soiled his/her pants, it was usual for the staff to leave the resident in the bed with just a brief on.</p> <p>An interview with State Registered Nurse Aide (SRNA) #1, on 06/14/12 at 4:00 PM, revealed she</p>	F 241	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>4) The DNS, SSD, or designee will monitor through observation, record review and resident interview to assure that residents receive care and services to maintain their dignity. The Administrator or designee will review concern/grievance reports and provide appropriate follow through. The data will be reviewed and analyzed monthly for three months and then quarterly thereafter at the Performance Improvement Committee Meeting with a subsequent plan of action developed and implemented as indicated. The Administrator is responsible for overall compliance.</p> <p>5. Completion date: 7/30/2012</p>	

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F 241	Continued From page 2 was the aide responsible for Resident #2, on 06/12/12 from 3:00 PM to 11:00 PM. She revealed the resident was usually in bed without pants on her shift. An interview with the Director of Nursing (DON), on 06/15/12 at 12:05 PM, revealed staff usually leave a resident's pants off while in the bed, unless the resident requested otherwise; however, she expected the staff to ensure the resident's brief was not exposed.	F 241	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	7/30/2012	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure services were provided by the facility that met professional standards of quality for one resident (#18), in the selected sample of twenty-four residents, related to therapeutic drug monitoring of a Digoxin level, and for one resident (#27), not in the selected sample, related to the failure to follow a physician's order during a medication pass. Findings include: 1. There was no evidence of a facility policy provided during the survey process which addressed therapeutic monitoring of medication levels. An interview with the Assistant Director of Nursing (ADON), and the Director of Nursing	F 281	F-281 1) Certified Medication Aide (CMA) #1 Involved in the medication pass observation was individually counseled regarding correct procedures. Resident #27 and #18 no longer reside at the facility. 2) The DNS and/or designee will conduct audit of the Medication Administration Records (MAR) to ensure all medications on the "Do Not Crush" list have an alert on the MAR. The DNS and /or designee will also Conduct and audit on all residents medications to ensure the appropriate therapeutic drug monitoring is in place as indicated. 3) The SDC will conduct an inservice with all Licensed Nurses and CMA's on meeting professional standards with an emphasis on medications that are on the "Do Not Crush" list and also regarding medications that require therapeutic drug monitoring. The SDC will include information regarding Meeting professional standards of quality as it relates to medication administration and therapeutic drug monitoring in the orientation of all new Licensed personnel and CMAs. 7/30/2012		

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F 281	<p>Continued From page 3</p> <p>(DON), on 06/15/12 at 10:35 AM, and on 06/15/12 at 1:45 PM, respectively, revealed there was no policy/procedure related to therapeutic drug monitoring. The facility followed standards of practice and corporate policies. The unit manager oversees the laboratory monitoring and notifies the physician.</p> <p>A record review revealed the facility admitted Resident #18 on 02/29/12 with diagnoses to include Dementia, Atrial Fibrillation, Angina, and Depression.</p> <p>A review of the admission Minimum Data Set (MDS), dated 03/07/12, revealed the facility assessed Resident #18 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13, ambulatory with limited assistance, and required extensive assistance with transfers.</p> <p>A review of the Comprehensive care plan for Altered Cardiac Output, dated 03/12/12, revealed no interventions/goals related to Digoxin therapy.</p> <p>A review of the quarterly MDS, dated 04/25/12, revealed the facility assessed Resident #18 as cognitively intact, walk-in room independent, and independent with transfers.</p> <p>Further record review revealed he/she had a (post-hospital) follow-up appointment with his/her cardiologist, on 05/01/12. A review of the two month follow-up examination and pacer check with the cardiologist, on 05/01/12, revealed an assessment to include: "Atrial Fibrillation on aspirin therapy only, rapid vent rate in today's</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>4) The DNS or designee reviewed a list of medications on the "Do Not Crush" list. The list of medications on the "Do Not Crush" list will be placed on each Medication Administration notebook. The SDC will conduct random medication pass observations weekly for one month and monthly thereafter. The DNS or designee will review all new admits, readmits and new medication orders daily (Monday – Friday) during the morning clinical meeting to ensure therapeutic drug monitoring is in place as indicated. The DNS or designee will monitor through medication pass observation, Medication Administration Record review, admit/readmit audit review, new medication orders and Consultant Pharmacist report review at least monthly for three months, then at least quarterly, to assure professional standards of clinical practice are met. The Administrator is responsible for overall compliance.</p> <p>5. Completion date: 7/30/2012</p>

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F 281	<p>Continued From page 4</p> <p>exam, history of mitral valve replacement" with a plan to include "Digoxin 0.25 mg every twelve hours times two doses, then 0.125 mg daily. " He/she returned to the facility with a new physician's order for Digoxin 0.25 milligrams (mg) every twelve hours times two doses, then administer Digoxin 0.125 mg every day.</p> <p>A review of the Medication Administration Record (MAR), dated May 2012, revealed Digoxin 0.25 mg by mouth daily related to atrial fibrillation. Digoxin 0.25 mg was administered on 05/02/12 and 05/03/12. Further review of the May 2012 MAR revealed Digoxin 0.125 mg was administered on 05/04/12 through 05/31/12.</p> <p>A review of the medication regimen completed by the pharmacy consultant, on 05/16/12, revealed no evidence of a review of the resident's Digoxin. An interview with the Pharmacy consultant, on 06/15/12 at 10:25 AM, revealed she was at the facility about every twenty-eight days and had not reviewed Resident #18's Digoxin yet. She revealed signs and symptoms of Digoxin toxicity included nausea, vomiting, diarrhea and visual disturbance.</p> <p>A review of the physician's order, dated 06/01/12 thru 06/30/12, revealed Digoxin 0.125 mg by mouth daily related to atrial fibrillation. A review of the MAR, dated 06/01/12 thru 06/10/12, revealed Digoxin 0.125 mg initialed as administered.</p> <p>A review of a nurse's note, dated 06/05/12, revealed a scheduled follow-up appointment with the cardiologist, due on 06/05/12 at 9:00 AM, was cancelled by Registered Nurse (RN) #1 at the resident's request due to not feeling well. An</p>	F 281		7/30/2012	

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F 281	<p>Continued From page 5</p> <p>interview with RN #1, on 06/15/12 at 2:00 PM, revealed she received the physician's order for the digoxin and would think about heart rate, laboratory tests, different side effects, and talk with the physician about those things. When Resident #18 returned from the physician's office, on 05/01/12, the orders were brought back. RN #1 notified the physician and he informed her that they (at the office) take care of their own laboratory tests. She revealed she did not document this information but should have. Resident #18's appointment was cancelled and was not rescheduled. Resident #18 had a stomach virus and she did not think about the laboratory test at that time. She revealed she did not think about nausea and vomiting being signs and symptoms of Digoxin toxicity.</p> <p>A review of a change in condition form, dated 06/10/12 at 7:15 PM, revealed the resident was ambulating from the bathroom to his/her bed and lost his/her balance and fell to the floor, landing on his/her right side. The resident complained of neck pain and was sent to the emergency room for neck pain and an evaluation for head injury.</p> <p>Observation and interview, on 06/15/12 at 8:40 AM and at 10:10 AM, revealed Resident #18 was laying in bed and did not recall any details about the fall that occurred on 06/10/12.</p> <p>A review of the hospital laboratory results, dated 06/10/12 at 9:31 PM, revealed a Digoxin level of 6.9 with the therapeutic range 0.8 - 2.0 nanograms per milliliter and a toxic range greater than 3.0 nanograms per milliliter.</p>	F 281		7/30/2012

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F 281	<p>Continued From page 6</p> <p>A review of nurse's notes from the facility, dated 06/11/12 at 2:00 AM, revealed Resident #18 was admitted to the hospital with Digoxin toxicity and renal failure.</p> <p>A review of the history and physical from the hospital, dated 06/11/12, revealed "in the emergency room, the resident was noted to have acute renal failure with a creatinine level of 3.4 and a digoxin level of 6.9. "</p> <p>A review of the cardiologist's consultation, dated 06/11/12, revealed the reason for the consultation was Digoxin toxicity. Resident #18 was found to be in renal failure with a creatinine level of 3.4 and to have Digoxin toxicity with a Digoxin level of 6.9. "</p> <p>An interview with the Unit Clerk, on 06/15/12 at 10:30 AM, revealed there was no therapeutic list to indicate which medication required therapeutic monitoring.</p> <p>An interview with LPN #1 (Unit Manager), on 06/15/12 at 12:35 PM, revealed the unit managers were responsible to monitor all new orders and attend morning meetings and relied on their knowledge base to know if a medication required therapeutic monitoring to include Digoxin levels.</p> <p>An interview with the attending physician, on 06/15/12 at 1:22 PM, revealed he would obtain a Digoxin level within the first two weeks. He expected the ordering physician, who ordered the medication, to obtain a level. He revealed signs and symptoms of toxicity may be nausea and</p>	F 281		7/30/2012	

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F 281	<p>Continued From page 7</p> <p>vomiting. The cardiologist who ordered the Digoxin was not available for an interview.</p> <p>An interview with the DON, on 06/15/12 at 10:20 AM, revealed it was the unit manager's responsibility to ensure laboratory tests were ordered and new orders were reviewed every morning.</p> <p>2. A review of the facility's policy/procedure for "Crushing Medication," dated 10/31/10, revealed nursing staff that administered medications could crush medications that were crushable and add it to a digestible medium to assist the resident in swallowing. When this occurred, care must be taken to ensure that crushing the medication would not present a hazard or nullify the drug's effectiveness.</p> <p>A review of the list of "Medications Not to be Crushed," undated, revealed Aspirin Enteric Coated (EC) should not be crushed because of the enteric coated formation.</p> <p>A review of the facility's policy/procedure for "Medication Administration," dated 08/31/11, revealed to read the medication record order and compare with the prescription label. If a discrepancy was noted, compare the medication record to the physician's orders in the resident's medical record.</p> <p>A review of Resident #27's physician's order, dated 06/01/12 through 06/30/12, revealed an order for Aspirin EC 81 milligrams (mg) by mouth once daily and Metoprolol Succinate (do not crush) 25 mg by mouth twice daily. Both</p>	F 281		7/30/2012

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F 281	<p>Continued From page 8</p> <p>medications were ordered on 12/23/11.</p> <p>An observation of a medication pass, on 06/13/12 at 10:25 AM, revealed Certified Medication Aide (CMA) #1 administered Aspirin EC 81 mg crushed in pudding; however, the label revealed "Do not crush or chew." She also administered Metoprolol Tartrate 25 mg, crushed in applesauce; however, the Medication Administration Record (MAR) specified Metoprolol Succinate 25 mg "Do not crush."</p> <p>Interview with CMA #1, on 06/13/12 at 3:25 PM, and on 06/14/12 at 2:25 PM, revealed she admitted the Aspirin EC should not have been crushed according to the medication label; however, she "overlooked" it and crushed the medication. She also stated that she thought Metoprolol Tartrate and Metoprolol Succinate was the same medication, and never questioned the order. She acknowledged the MAR specified "do not crush" the medication; however, she "overlooked" it as well.</p> <p>An interview with the pharmacy's General Manager, on 06/14/12 at 1:30 PM, revealed Metoprolol Tartrate was an immediate release medication and Metoprolol Succinate was controlled release. She revealed when a physician ordered Metoprolol twice daily, the pharmacy automatically sent Metoprolol Tartrate because Metoprolol Succinate was usually given once a day. The pharmacy had sent the Metoprolol Tartrate since the order date, 12/23/11. Additionally, she revealed Aspirin EC was not designed to crush. She revealed crushing the medication would allow the medication to dissolve in the stomach, possibly</p>	F 281		7/30/2012

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F 281	Continued From page 9 causing gastrointestinal upset. An interview with the DON, on 06/15/12 at 12:05 PM, revealed she expected the CMA to report medication discrepancies to the Charge Nurse. She expected the CMA to also check the label of the medication with the MAR, and utilize the "do not crush" list in the front of the MAR while administering medications.	F 281	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure it was free of medication error rates of five percent or greater. An observation of a medication pass, on 06/13/12 at 10:25 AM, revealed there were forty opportunities with two errors which resulted in a medication error rate of five percent (5%). Findings include: A review of the facility's policy/procedure for "Crushing Medication," dated 10/31/10, revealed nursing staff that administered medications could crush medications that were crushable and add it to a digestible medium to assist the resident in swallowing. When this occurred, care must be taken to ensure that crushing the medication would not present a hazard or nullify the drug's	F 332	F-332 1) Resident #27 no longer resides at the facility. The DNS will individually counsel CMA #1. 2) The SDC and/or Pharmacy Consultant will conduct individual medication pass observations for all Licensed Nurses and CMAs to determine compliance. 3) The SDC will conduct individualized in servicing for the licensed staff and CMAs on the provision of pharmacy services including the policy and procedures for administering medications according to physician's order and medications on the "Do Not Crush" list. The SDC, DNS, ADNS, UMs and/or WS will conduct random medication pass reviews with licensed staff members at least weekly for one month then at least monthly for three months and quarterly thereafter and provide inservicing and/or counseling as indicated.	7/30/12	

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 332	<p>Continued From page 10 effectiveness.</p> <p>A review of the list of "Medications Not to be Crushed," undated, revealed Aspirin Enteric Coated (EC) should not be crushed because of the enteric coated formation.</p> <p>A review of the facility's policy/procedure for "Medication Administration," dated 08/31/11, revealed to read the medication record order and compare with the prescription label. If a discrepancy was noted, compare the medication record to the physician's orders in the resident's medical record.</p> <p>A review of Resident #27's physician's order, dated 06/01/12 through 06/30/12, revealed an order for Aspirin EC 81 milligrams (mg) by mouth once daily and Metoprolol Succinate (do not crush) 25 mg by mouth twice daily. Both medications were ordered on 12/23/11.</p> <p>An observation of a medication pass, on 06/13/12 at 10:25 AM, revealed Certified Medication Aide (CMA) #1 administered the following medications to Resident #27:</p> <ol style="list-style-type: none"> 1. Aspirin EC 81 mg crushed in pudding; however the label revealed "Do not crush or chew." 2. Metoprolol Tartrate 25 mg, crushed in applesauce; however, the Medication Administration Record (MAR) specified Metoprolol Succinate 25 mg "Do not crush." <p>Interview with CMA #1, on 06/13/12 at 3:25 PM and on 06/14/12 at 2:25 PM, revealed the Aspirin EC should not have been crushed, according to the medication label; however, she "overlooked" it and crushed the medication. She also stated that</p>	F 332	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>4)The DNS, SDC, ADNS, UMs and/or WS will monitor through observation, MAR review and Pharmacy Consult and report review at least monthly for three months, the at least quarterly, to assure medications are administered according to physicians orders and facility policy and procedure. The Administrator is responsible for overall compliance.</p>	7/30/12	

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F 332	Continued From page 11 she thought Metoprolol Tartrate and Metoprolol Succinate was the same medication, and never questioned the order. She acknowledged the MAR specified "do not crush" the medication; however, she "overlooked" it as well. An interview with the pharmacy's General Manager, on 06/14/12 at 1:30 PM, revealed Metoprolol Tartrate was an immediate release medication and Metoprolol Succinate was controlled release. She revealed when a physician ordered Metoprolol twice daily, the pharmacy automatically sent Metoprolol Tartrate because Metoprolol Succinate was usually given once a day. The pharmacy had sent the Metoprolol Tartrate since the order date, 12/23/11. Additionally, she revealed Aspirin EC was not designed to crush. She revealed crushing the medication allowed the medication to dissolve in the stomach, possibly causing gastrointestinal upset. An interview with the Director of Nursing (DON), on 06/15/12 at 12:05 PM, revealed she expected the CMA to report medication discrepancies to the Charge Nurse. She expected the CMA to also check the label of the medication with the MAR, and utilize the "do not crush" list in the front of the MAR while administering medications.	F 332		7/30/2012	
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F 469			

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F 469	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to maintain an effective pest control program to ensure the environment was free of crawling insects, for one resident (#12), in the selected sample of twenty-four residents. Observations during the survey revealed ants were on the resident's bed, behind the resident's bed, on the baseboard, and on the floor of the resident's room. Findings include: A review of the facility's policy/procedure, "Pest Control," dated 10/31/08, revealed the facility was to conduct routine inspections for evidence of pests. The staff members were to report the following insect or pest related information to the housekeeping/maintenance supervisor: the type of problem; the location; the person reporting; and the time reported. Problems found during the inspections were to be documented and the remedial actions were to be taken. Employees were to be trained on preventative measures, unsanitary conditions, etc. The facility was to have a contract with a licensed pest control vendor. Storage and food preparation areas were to be kept clean. Food spills were to be cleaned up promptly. Dry foodstuffs were to be kept in closed containers or bins. Food was not allowed to be stored in uncovered containers, in the resident rooms, or elsewhere. An observation of Resident #12's room, on 06/12/12 at 6:30 PM, revealed an ant crawling on	F 469	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F-469 1) The Maintenance Supervisor eradicated ants from Resident #12s room. 2) All resident rooms and common areas will be checked for ants and/or other pest by the Maintenance Supervisor. 3) The Staff Development Coordinator will include information of the facility pest control program in the orientation of new personnel. The Maintenance Supervisor and the Administrator will review the current pest control program and implement corrective measures if indicated. The Maintenance Supervisor or Assistant will conduct daily rounds (Monday-Friday) to ensure that the facility is free of pests. 4) The Maintenance Supervisor or Assistant will monitor through direct observation on a daily basis (Monday-Friday) to assure that the facility had an effective pest control program. The data will be reviewed and analyzed monthly for three months and the quarterly thereafter at the Performance Improvement Committee meeting with a subsequent plan of action developed and implemented as indicated. The Administrator is responsible for overall compliance.	7/30/12	

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F 469	<p>Continued From page 13</p> <p>the resident's pillow near the resident's head. Further observation revealed several ants crawling on the floor, behind the resident's bed, and near the baseboard.</p> <p>An interview with Housekeeper #1, on 06/12/12 at 6:40 PM, revealed she was unaware of a problem with ants in this area. The housekeeper went back to the hallway and brought a spray bottle and stated she would take care of the problem.</p> <p>An observation of Resident #12's room, on 06/13/12 at 10:05 AM, revealed ants were still noted to be crawling behind the bed and near the baseboard.</p> <p>An observation during a medication pass, on 06/13/12 at 12:35 PM, revealed ants were on the resident's bed, around and under the fall safety mat on the floor, and on the baseboard near the head of the resident's bed.</p> <p>Observation, on 06/15/12 at 10:10 AM, revealed ants were in Resident #12's room crawling on a plastic drawer storage unit, and in the corner of the room near the resident's bed.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 6/13/12 at 12:30 PM, revealed she was not aware ants were a problem in Resident #12's room and someone should have notified housekeeping and/or maintenance to take care of the problem.</p> <p>An interview with Housekeeping Staff #1, on 06/14/12 at 10 AM, revealed she had sprayed a bleach solution on the ants in Resident #12's room, on 06/12/12, but did not notify anyone.</p>	F 469		7/30/2012	

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F 469	Continued From page 14 An interview with the Maintenance Supervisor, on 06/15/12 at 12:30 PM, revealed he was unaware of the ants and staff should have notified him when the ants were first observed. There was also a maintenance book on the units for staff to put that information in.	F 469		7/30/2012	

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW	STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1968</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Ten (10) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke and heat detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 06/13/12. Kindred Transitional Care & Rehab - Rosewood was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred seventy-six (176) beds with a census of one-hundred fifty (150) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>This Plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Transitional Care And Rehabilitation, Rosewood does not admit that the deficiencies listed on the HCFA Form 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE *A. M. ...* (X6) DATE *7/4/12*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW			STREET ADDRESS, CITY, STATE, ZIP CODE 650 HIGH ST. BOWLING GREEN, KY 42101	
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K 018	<p>Continued From page 2</p> <p>facility is licensed for one-hundred seventy-six (176) beds with a census of one-hundred fifty (150) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/13/12 between 9:30 AM and 4:30 PM, with the Maintenance Supervisor revealed the corridor doors to rooms 143, 140, 136, 105, 126, 128, 129, 131, 134, 113, 115, 114, 118, 118, 123, 125, 156, 159, 161, 188, 189, 192, 177, 182 and 181 had a gap too large around the jamb and would not resist the passage of smoke.</p> <p>Interview, on 06/13/12 between 9:30 AM and 4:30 PM, with the Maintenance Supervisor revealed he was aware that some doors large a gap that would not resist the passage of smoke. The facility has a bid to replace 15 doors that had large gaps between the doors and the jambs. Further interview revealed the Maintenance Supervisor was not aware of the allowable gap in the corridor doors.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80,</p>	K 018	<p><u>K 18</u></p> <ol style="list-style-type: none"> The doors of rooms of rooms 105, 113, 114, 115, 116, 118, 123, 125, 126, 128, 129, 131, 134, 136, 140, 143, 156, 159, 161, 177, 181, 182, 188, 189, 192. Seventeen doors will be replaced by Underwood Construction; The remaining eight will be sealed to resist the passage of smoke. Maintenance Director inspected all rooms in the building for smoke gaps in the doors. All doors shall be inspected quarterly for functionality and code compliance per Kindred Preventive Maintenance policy. Maintenance director will do inspections. Maintenance Director will report any doors not in compliance with smoke passage code to Administrator. Administrator will track and trend and report findings to PI committee and appropriate action will be taken Completion date 8/13/2012 	

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K 018	Continued From page 3 Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22.N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018			
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct	K 025			

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K 025	<p>Continued From page 4</p> <p>penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers in accordance with NFPA standards. The deficiency had the potential to affect four (4) of ten (10) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred seventy-six (176) beds with a census of one-hundred fifty (150) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/13/12 between 8:10 AM and 9:00 AM, with the Maintenance Supervisor revealed the smoke partition, extending above the ceiling located next to room# 186 & 187, was not properly sealed. The barrier failed to be properly sealed from piping and wires. Further observation showed the smoke barrier next to room# 109 & 107 was not a fire rated wall with a fire resistance rating of not less than 1/2 hour. The wall was constructed of a cardboard/Masonite material with a plastic barrier in front of the wall.</p> <p>Interview, on 06/13/12 between 8:10 AM and 9:00 AM, with the Maintenance Supervisor revealed he was not aware of the penetrations in the smoke barrier and that he was aware the smoke barrier was not a rated wall but was unaware the wall</p>	K 025	<p><u>K25</u></p> <ol style="list-style-type: none"> 1. Partitions extending above ceiling located in H-Hall next to Rooms 186 and 187 has been properly sealed to prevent passages of smoke by Maintenance Director. The smoke wall extending above A-Hall smoke door next to room 107 will upgrade to a one hour smoke wall by addition of 5/8" dry wall installed on both sides of 2x4 studding. 2. Maintenance director will check the attic of the entire building for any penetrations in smoke partitions. 3. Attic partitions will be inspected quarterly and after phone/cable company has been in attic. Maintenance director will do inspection. 4. Maintenance director will report any non-compliance findings to Administrator. Administrator will track and trend findings and report to PI meeting with appropriate action taken. 5. Completion date 8/13/2012 	
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K 025	Continued From page 5 must have a minimum fire resistance rating. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.	K 025		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire	K 029		

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
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K 029	<p>Continued From page 6</p> <p>extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of ten (10) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred seventy-six (176) beds with a census of one-hundred fifty (150) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/13/12 at 9:37 AM, with the Maintenance Supervisor revealed the front and back dry storage areas in the kitchen did not have separation from the rest of the kitchen. The areas have exits from the kitchen passing through the areas where the combustibles are stored.</p> <p>Interview, on 06/13/12 at 9:37 AM, with the</p>	K 029	<p><u>K29</u></p> <ol style="list-style-type: none"> 1. The front and back combustible dry storage in the kitchen will be separated from the rest of the kitchen to maintain compliance with Life Safety hazardous area regulations. 2. Maintenance director will check all door closings and for non-compliance fire rated doors. 3. All dry storage areas shall be inspected quarterly for Code Compliance. Maintenance Director will do inspections. 4. Maintenance director will report any non-compliance findings to the Administrator. Administrator will track and trend findings and report to PI meeting with appropriate action taken. 5. Completion date 8/13/2012 	

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K 029	Continued From page 7 Maintenance Supervisor revealed he was unaware the storage areas needed to be separated from other use areas or corridors for exiting the building. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than	K 029		

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K 029	Continued From page 8 those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of ten (10) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred seventy-six (176) beds with a census of one-hundred fifty (150) on the day of the survey. The findings include: Observation, on 06/13/12 between 11:30 AM and 3:30 PM, with the Maintenance Supervisor revealed the egress gates around the building did not have a code posted at the gates or no delay to release them. The gates would not open unless the fire alarm went off or the code was	K 038	<u>K38</u> 1. Egress gates identified have had codes posted at the gates. 2. Maintenance director inspected all gates for proper out swings and codes. 3. The egress gates will be inspected monthly for Code Compliance. 4. Maintenance director will report any gates not in compliance to the Administrator. Administrator will track and trend findings and report to PI meeting with appropriate action taken. 5. Completion date: 6/15/2012	

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K 038	Continued From page 9 entered to open the gates. Interview, on 06/13/12 between 11:30 AM and 3:30 PM, with the Maintenance Supervisor revealed he was unaware the doors could not be locked and dependent upon the fire alarm to release the doors. Further observation revealed the Maintenance Supervisor did not know the gate code and had to reset the code to open the gate. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks, Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors	K 038			

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K 038	<p>Continued From page 10 of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway</p>	K 038		

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K 038	Continued From page 11 that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038		

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K 040 SS-D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure exit discharge doors opened in the direction of egress in accordance with NFPA standards. The deficiency had the potential to affect two (2) of ten (10) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred seventy-six (176) beds with a census of one-hundred fifty (150) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/13/12 between 10:30 AM and 3:30 PM, with the Maintenance Supervisor revealed the exit gates at the front courtyard, the reflection courtyard, and the exit gate at the end of the reflections corridor did not swing outward. The gate would have to be pulled against egress travel in the event of an evacuation.</p> <p>Interview, on 06/13/12 between 10:30 AM and 3:30 PM, with the Maintenance Supervisor revealed he was not aware the exit discharge gate needed to open in the direction of egress.</p> <p>NFPA 101 (2000 edition) 7.2.1.4.3 A door shall swing in the direction of egress travel where used in an exit enclosure or where serving</p>	K 040	<p><u>K40</u></p> <ol style="list-style-type: none"> 1. The gates on the front courtyard, reflections courtyard and end of the reflections corridor have been adjusted to swing outward in the direction of egress. 2. Maintenance director will inspect all gates to open outward in the direction of egress. 3. The egress gates will be inspected monthly for Code Compliance. 4. Maintenance director will report any non-compliance findings to Administrator. Administrator will track and trend findings and report to PI meeting with appropriate action taken. 5. Completion date: 6/15/2012 	
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K 040	Continued From page 13 a high hazard contents area, unless it is a door from an individual living unit that opens directly into an exit enclosure.	K 040		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of ten (10) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred seventy-six (176) beds with a census of one-hundred fifty (150) on the day of the survey. The findings include: Observation, on 06/13/12 between 9:40 AM and 3:30 PM, with the Maintenance Supervisor revealed the exterior exit at the rear of the kitchen had a single bulb fixture for lighting the exit. Further observation showed the reflection nurses station exit has no exterior lighting. Interview, on 06/13/12 between 9:40 AM and 3:30 PM, with the Maintenance Supervisor revealed he was aware the lighting fixtures serving the exterior exits must include more than one bulb	K 045	<u>K45</u> 1. One additional egress light fixture has been added to the kitchen exit. The Reflections exterior door opens into a courtyard; the exit sign was removed and a "Not an Exit" sign placed on the door. 2. Maintenance Director inspected all Exit for proper lighting. 3. The Exit lighting will be inspected monthly for Code compliance. 4. Maintenance director will inspect sprinkler system monthly for 3 months and then quarterly thereafter, and report any non-compliance issues to Administrator who will track and trend and report findings to PI committee. 5. Date of completion will be: 6/21/2012	

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K 045	Continued From page 14 and the facility had added lighting recently, but failed to properly light these exits. Exit lighting must be arranged so the failure of a single bulb will not leave the exit in complete darkness. Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on staff interview and observation, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect ten (10) of ten (10) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred seventy-six (176) beds with a census of one-hundred fifty (150) on the day of the survey. The findings include: Observation and record review, on 06/13/12 at 9:30 AM, with the Maintenance Supervisor revealed that the emergency lights, with battery	K 046	<u>K46</u> 1. Emergency battery light testing has been conducted for 1 1/2 hour; annual testing documentation is on file. 2. Maintenance Director tested all battery lights. 3. The battery lights will be checked monthly for Code Compliance. 4. Maintenance director will report any battery lights not Compliance to Administrator, Administrator will track and trend and report findings to PI Committee and appropriate action will be taken. 5. Completion date will be: 6/15/2012	

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K 046	Continued From page 15 backup, located throughout the facility were not tested for 1-1/2 hours within the last year. Interview, on 06/13/12 at 9:30 AM, with the Maintenance Supervisor revealed he was aware the lighting had to be tested annually for 1-1/2 hours but discovered the last test was on 4-22-11. Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic,	K 046		

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 046	Continued From page 16 battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046	<p>K73</p> <ol style="list-style-type: none"> 1. Stuffed Animals and hanging decorations that are not flame resistant have been removed from the facility. 2. The Executive Director and Maintenance Director will make rounds throughout the facility to ensure there were not any decorations that are not flame resistant with correction made as necessary. 3. Staff will be in-serviced by 7/27/2012 and Staff Development Coordinator to recognize and report to the Administrator or Maintenance Director any items being brought into the center by visitors or family members that might not be fire resistant. The Admissions Coordinator will inform Residents and Family members upon admission that only flame resistant decorations will be allowed in the center. 4. Assigned Angels will be instructed to monitor on their daily rounds for any new decorations which might not be fire resistant and report to the Maintenance Director or Executive Director. The Maintenance Director will make weekly rounds through out the center and will report to the PI Committee monthly for three months and/or until the committee determines this deficiency to have been corrected and sustained. The Executive Director will monitor compliance 5. Completion date will be: 7/27/2012 	
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect five (5) of ten (10) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred seventy-six (176) beds with a census of one-hundred fifty (150) on the day of the survey. The findings include: Observation, on 06/13/12 between 9:30 AM and 4:30 PM, with the Maintenance Supervisor revealed several stuffed animals and fake floral arrangements throughout the facility with no flame retardant applied. Room numbers 180, 182, 192, 170, 172, 176, 179, 143, 141, 147, 146, 158, 161, and 185 are some examples of this deficiency Interview, on 06/13/12 between 9:30 AM and 4:30 PM, with the Maintenance Supervisor revealed	K 073		

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K 073	Continued From page 17 they were aware decorations were required to be treated with a fire retardant spray and that any item brought into the facility was supposed to be checked in on arrival. Further observation showed the facility had sent out a letter to the families of the residents to remove the decorations from the rooms by June 15, 2012. The facility was made aware the decorations are not required to be removed, but if the decorations are going to be in the rooms they must be treated with a flame-retardant spray. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect six (6) of ten (10) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred seventy-six (176) beds with a census of one-hundred fifty (150) on the day of the survey. The findings include:	K 147		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/13/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 18 Observations, on 06/13/12 between 9:30 AM and 4:30 PM, with the Maintenance Supervisor revealed: 1) An extension cord was plugged into a phone charger in room# 137. 2) An extension cord was in use in the Dietary Office. 3) Two beds were plugged into a power strip in room# 135. 4) A wheelchair charger was plugged into a power strip in room# 136. 5) A power strip was plugged into another power strip; a microwave was plugged into a power strip, and medical equipment was plugged into a power strip in the respiratory therapy office. 6) An extension cord was plugged in the television, as well as a refrigerator was plugged into a power strip in room# 103. 7) A refrigerator was plugged into a power strip as well as a coffee maker; also a power strip was plugged into another power strip in the MDS coordinator ' s office. 8) A bed was plugged into a power strip in room# 131. 9) An extension cord was plugged into a phone charger in room # 134. 10) Two beds and a refrigerator were plugged into a power strip in room# 114. 11) An oxygen concentrator and an air mattress were plugged into a power strip in room# 120. 12) A bed was plugged into a power strip in room# 122. 13) An oxygen concentrator was plugged into a power strip in room# 124. 14) An extension cord was in use in room# 125. → Ivin P.S. 15) A refrigerator was plugged into a power strip	K 147	<u>K147</u> 1 The extension cords and power strips was removed from these areas. 2. Maintenance director did building wide room inspections for inappropriate power strips and extension cords. 3. Maintenance Director and assigned management will monitor the facility power strips for proper use and will remove extension cords if found. 4. The weekly finding will be reported to Administrator who will track and trend results and report to monthly PI Committee and appropriate action will be taken. 5. Completion date will be: 6/22/2012	

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K 147	Continued From page 19 in room# 161. Interview, on 06/13/12 between 9:30 AM and 4:30 PM, with the Maintenance Supervisor revealed he was not aware the extension cords were only for temporary use, or the power strips were being misused. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147			